		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042051

Facility Name: Alden Trails

Address: 273 E. Army Trail RD (Number) Bloomingdale (City) 60108 (Zip Code)

County:

Telephone Number: (630) 671-1990 **Fax #** (630)671-0540

IDPA ID Number: 36-3966582

Date of Initial License for Current Owners: 05/19/98

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773)286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven M. Kroll
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,456			5,456	13
14	TOTALS	5,456			5,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.42%

D. How many bed-hold days during this year were paid by Public Aid?
382 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	47,872	1,984		49,856	265	50,121		50,121			1
2	Food Purchase		18,951		18,951	(3,515)	15,436	17	15,453			2
3	Housekeeping	6,366	6,040		12,406		12,406		12,406			3
4	Laundry		1,078		1,078		1,078		1,078			4
5	Heat and Other Utilities			17,100	17,100		17,100	96	17,196			5
6	Maintenance	2,236		31,377	33,613		33,613	1,145	34,758			6
7	Other (specify):*			197	197		197		197			7
8	**TOTAL General Services**	56,474	28,053	48,674	133,201	(3,250)	129,951	1,258	131,209			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	345,737	8,638	469	354,844		354,844	(1,242)	353,602			10
10a	Therapy											10a
11	Activities			1,586	1,586		1,586		1,586			11
12	Social Services	30,573		21,909	52,482		52,482		52,482			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	376,310	8,638	27,964	412,912		412,912	(1,242)	411,670			16
	C. General Administration											
17	Administrative	23,365			23,365		23,365		23,365			17
18	Directors Fees											18
19	Professional Services			82,864	82,864		82,864	(73,043)	9,821			19
20	Dues, Fees, Subscriptions & Promotions			2,389	2,389		2,389	(1,465)	924			20
21	Clerical & General Office Expenses	25,600	1,160	4,301	31,061		31,061	(6,233)	24,828			21
22	Employee Benefits & Payroll Taxes			62,520	62,520	3,250	65,770	5,600	71,370			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,331	1,331		1,331	1,216	2,547			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,327	10,327		10,327	2,343	12,670			26
27	Other (specify):* **bad debt**			8,108	8,108		8,108	(8,108)				27
28	**TOTAL General Administration**	48,965	1,160	171,840	221,965	3,250	225,215	(79,690)	145,525			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	481,749	37,851	248,478	768,078		768,078	(79,674)	688,404			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Trails #0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			5,512	5,512		5,512	45,105	50,617			30
31	Amortization of Pre-Op. & Org.							627	627			31
32	Interest			98,981	98,981		98,981	13,912	112,893			32
33	Real Estate Taxes							14,131	14,131			33
34	Rent-Facility & Grounds			111,898	111,898		111,898	(111,898)				34
35	Rent-Equipment & Vehicles			6,345	6,345		6,345	2,242	8,587			35
36	Other (specify):*							7,238	7,238			36
37	**TOTAL Ownership**			222,736	222,736		222,736	(28,643)	194,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,845	5,131	7,976		7,976	(1,864)	6,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,637	66,637		66,637		66,637			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,845	71,768	74,613		74,613	(1,864)	72,749			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	481,749	40,696	542,982	1,065,427		1,065,427	(110,181)	955,246			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(10,100)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(157)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,108)	27		24
25	Fund Raising, Advertising and Promotional	(1,102)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,467)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,084)	various	34
35	Other- Attach Schedule	(78,630)	pg5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (90,714)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (110,181)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Alden Trails

ID# 0042051

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utilities	$ (266)	5	1
2				2
3	Intercompany Interest	(82,512)	32	3
4				4
5				5
6	Backout: Late Fee on p/s	(597)	21	6
7	back out 30.13% of IHCA dues	(261)	20	7
8	Correct deprec expense to detail (tb not yet adj for ytd de	4,203	30	8
9	Back out: prior yr vend settlement credit	1,008	21	9
10	Back out: rent expense	(205)	34	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(78,630)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Trails # 0042051 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	17	0	0	0	0	0	0	0	17	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(266)	0	362	0	0	0	0	0	0	0	0	96	5
6	Maintenance	0	0	1,177	0	0	0	(32)	0	0	0	0	1,145	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(266)	0	1,539	17	0	0	(32)	0	0	0	0	1,258	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(907)	(335)	0	0	0	0	0	0	(1,242)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(907)	(335)	0	0	0	0	0	0	(1,242)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,092	(76,135)	0	0	0	0	0	0	0	0	(73,043)	19
20	Fees, Subscriptions & Promotions	(1,520)	0	55	0	0	0	0	0	0	0	0	(1,465)	20
21	Clerical & General Office Expenses	(9,689)	0	3,230	140	86	0	0	0	0	0	0	(6,233)	21
22	Employee Benefits & Payroll Taxes	0	0	5,580	0	20	0	0	0	0	0	0	5,600	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,216	0	0	0	0	0	0	0	0	1,216	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,315	28	0	0	0	0	0	0	0	0	2,343	26
27	Other (specify):*	(8,108)	0	0	0	0	0	0	0	0	0	0	(8,108)	27
28	**TOTAL General Administration**	(19,317)	5,407	(66,026)	140	106	0	0	0	0	0	0	(79,690)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,583)	5,407	(64,487)	(750)	(229)	0	(32)	0	0	0	0	(79,674)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Alden Trails **#** 0042051 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,203	28,497	10,584	0	1,821	0	0	0	0	0	0	45,105	30
31	Amortization of Pre-Op. & Org.	0	462	164	0	0	1	0	0	0	0	0	627	31
32	Interest	(82,512)	91,580	4,834	0	8	2	0	0	0	0	0	13,912	32
33	Real Estate Taxes	0	13,449	679	0	3	0	0	0	0	0	0	14,131	33
34	Rent-Facility & Grounds	(205)	(111,693)	0	0	0	0	0	0	0	0	0	(111,898)	34
35	Rent-Equipment & Vehicles	0	0	2,242	0	0	0	0	0	0	0	0	2,242	35
36	Other (specify):*	0	7,238	0	0	0	0	0	0	0	0	0	7,238	36
37	**TOTAL Ownership**	(78,514)	29,533	18,503	0	1,832	3	0	0	0	0	0	(28,643)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	(38)	(1,826)	0	0	0	0	0	(1,864)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	(38)	(1,826)	0	0	0	0	0	(1,864)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(98,097)	34,940	(45,984)	(750)	1,565	(1,823)	(32)	0	0	0	0	(110,181)	45

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent revenue	$ 111,693	Alden of Bloomingdale Limited Partnership		$	$ (111,693)	1
2	V	32	Revenue from investments	16,609	Alden of Bloomingdale Limited Partnership			(16,609)	2
3	V	19	Audit		Alden of Bloomingdale Limited Partnership		1,267	1,267	3
4	V	19	Misc Admin Expense		Alden of Bloomingdale Limited Partnership		1,825	1,825	4
5	V	33	Real estate taxes		Alden of Bloomingdale Limited Partnership		13,449	13,449	5
6	V	26	Insurance expense		Alden of Bloomingdale Limited Partnership		2,315	2,315	6
7	V	32	Interest on Loans - Prudential		Alden of Bloomingdale Limited Partnership		30,671	30,671	7
8	V	32	Interest on operating loss loan		Alden of Bloomingdale Limited Partnership		23,003	23,003	8
9	V	36	Mortgage insurnace premuim		Alden of Bloomingdale Limited Partnership		7,238	7,238	9
10	V	30	Depreciation		Alden of Bloomingdale Limited Partnership		28,497	28,497	10
11	V	31	Amortization		Alden of Bloomingdale Limited Partnership		462	462	11
12	V	32	Interest on mortgage		Alden of Bloomingdale Limited Partnership		20,403	20,403	12
13	V	32	Prepayment Charged on Debt		Alden of Bloomingdale Limited Partnership		34,112	34,112	13
14	Total			$ 128,302			$ 163,242	$ * 34,940	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	$	Alden Management Services		$ 5,580	$ 5,580	15
16	V	19	profess. Fees	77,743	Alden Management Services		1,608	(76,135)	16
17	V	21	g & a		Alden Management Services		3,230	3,230	17
18	V	5	utilities		Alden Management Services		362	362	18
19	V	6	maintenance		Alden Management Services		1,177	1,177	19
20	V	24	auto/travel		Alden Management Services		1,216	1,216	20
21	V	26	insurance		Alden Management Services		28	28	21
22	V	20	dues & subscriptions		Alden Management Services		55	55	22
23	V	30	depreciation		Alden Management Services		10,584	10,584	23
24	V	31	amortization		Alden Management Services		164	164	24
25	V	33	real estate tax		Alden Management Services		679	679	25
26	V	35	rent-equip/vehicles		Alden Management Services		2,242	2,242	26
27	V	32	interest		Alden Management Services		4,834	4,834	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,743			$ 31,759	$ * (45,984)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube-feeding	$	Pyramid Health Care	0.00%	$ 17	$ 17	15
16	V	10	nursing supplies	1,087	Pyramid Health Care		180	(907)	16
17	V	39	per diems/other supplies		Pyramid Health Care				17
18	V	21	gern'l& admin		Pyramid Health Care		140	140	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,087			$ 337	$ * (750)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 1/1/2003 Ending: 12/31/203

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	drugs	$ 107	Forum Extended Care II	0.00%	$ 91	$ (16)	15
16	V		10	house sock	2,161	Forum Extended Care II		1,826	(335)	16
17	V		39	I. V.	141	Forum Extended Care II		119	(22)	17
18	V		22	employee benefits		Forum Extended Care II		20	20	18
19	V		21	gen'l & admin		Forum Extended Care II		86	86	19
20	V		32	interest		Forum Extended Care II		8	8	20
21	V		33	real estate tax		Forum Extended Care II		3	3	21
22	V		30	depreciation		Forum Extended Care II		1,821	1,821	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 2,409			$ 3,974	$ * 1,565	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	therapy	$ 5,181	Community Physical Therapy	0.00%	$ 3,355	$ (1,826)	15
16	V	32	interest		Community Physical Therapy		2	2	16
17	V	31	amortization		Community Physical Therapy		1	1	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,181			$ 3,358	$ * (1,823)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	repairs and maintenance	$ 9,892	Alden Bennett Construction		$ 9,860	$ (32)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,892			$ 9,860	$ * (32)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NURSING CENTER - TRAILS # 42051 Report Period Beginning 01/01/03 Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
ANC Waterford	Aurora
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC - Governors Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd A Schlossberg	President		100.00	344,669	0.216	0.54	Salary	$ 1,883	17-1	1
2	Lauren Magnussen	Clinical Coordinator		A	86,592	0.216	0.54	Salary	473	10-1	2
3	Terry Magnussen	Maintenance Supr		A	83,736	0.216	0.54	Salary	458	6-1	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc										6
7	b. Lauren Magnusson is the daugher of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and constructon.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,814		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773)286-3883
Fax Number: (773)286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Prudential		X	Mortgage-paid off	$6,066.00	1997	$ 873,700	$	9/2037	7.9700	$ 30,671	1
2	Cambridge		X		$6,367.00	06/02	339,267	335,440	9/2037	6.8600	23,003	2
3	Cambridge		X	Mortgage		09/03	873,700	871,679			20,403	3
4	Prepayment charge on debt		X	extinguish debt							34,112	4
5												5
	Working Capital											
6	Related party - AMS	X									4,834	6
7	Related party - FECII	X									8	7
8	Related Party -CPT	X									2	8
9	TOTAL Facility Related				$12,433.00		$ 2,086,667	$ 1,207,119			$ 113,033	9
	B. Non-Facility Related*											
10	Offset interest expense with Bloom Assoc interest income										(140)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (140)	14
15	TOTALS (line 9+line14)						$ 2,086,667	$ 1,207,119			$ 112,893	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 7,238 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 11,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 12,365	2
3. Under or (over) accrual (line 2 minus line 1).		$ 465	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 12,984	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 13,449	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	992	8
	1999	13,031	9
	2000	10,793	10
	2001	11,137	11
	2002	12,365	12

Accrual based on 3% increase over prior year bill

Amount recorded as paid in 2003 represents 1/3 of all real estate tax parcels assessed to Bloomingdale Assoc entities.Old Town East =$12,153.67, Old Town West = $13,608.88, Trails = $13,188.59

TOTAL =$38,951.14 1/3 of Total =$12,983.71

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Trails COUNTY

FACILITY IDPH LICENSE NUMBER 0042051

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773)286-3883 FAX #: (773)286-3743

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200.

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-23-301-016	Nursing Home Facility	$ 12,365.44	$ 12,365.44
2.		Related Party - Alden Management	$ 125,008.00	$ 164.00
3.		Related Party - Forum	$ 8,317.00	$ 3.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 145,690.44	$ 12,532.44

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,610 B. General Construction Type: Exterior Brick Veneer Frame wood Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	38,474	1995	$ 147,679	1
2					2
3	TOTALS	38,474		$ 147,679	3

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 15,909	$	22	$	$	$ 15,909	4
5	16		1997	1997	934,861	23,372	40	23,372		129,165	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	2 TV Modules			1999	1,775	355	5	355		1,597	10
11	Sprinkler System			1999	1,690	113	15	113		545	11
12	Replace heads-Irrigation system			1998	1,653	110	15	110		615	12
13	Cellozzi Ettleson - Auto Repair			2000	5,741	1,435	4	1,435		5,741	13
14	Carpentry, Ceramic,Quarry, Corain tops			2003	14,274	1,427	10	1,427		1,427	14
15	Bill's Auto Repair			2003	817	817	1	817		817	15
16	Panels			2003	5,175	1,035	5	1,035		1,035	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 981,896	$ 28,665		$ 28,665	$	$ 156,852	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		$ 1,053,623	$ 30,942		$ 30,942	$	$ 209,674	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 192,187	$ 15,441	$ 15,441	$	various	$ 99,766	71
72	Current Year Purchases	7,046	1,084	1,084		various	1,084	72
73	Fully Depreciated Assets	40,851	1,098	1,098		various	40,851	73
74								74
75	TOTALS	$ 240,083	$ 17,623	$ 17,623	$		$ 141,701	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	:'98-'03	$ 11,860	$ 2,052	$ 2,052	$	3	$ 11,658	76
77										77
78										78
79										79
80	TOTALS			$ 11,860	$ 2,052	$ 2,052	$		$ 11,658	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,453,245	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,617	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,617	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 363,033	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$ n/a	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related party - cost backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1/1/98
Ending 6/1/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 90,808
13.	/2005	$ 90,808
14.	/2006	$ 12,612

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 3,907 Description: Copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	patient transport		$ 210.00	$ 2,438	17
18					18
19					19
20					20
21	TOTAL		$ 210.00	$ 2,438	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nurses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs		$		$ 2,250	$		$ 2,250	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				934			934	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				2,158			2,158	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	See page 16A	# of prescrpts					1,578		1,578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	See page 16A						(808)		(808)	13
14	TOTAL				$		$ 5,342	$ 770		$ 6,112	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Trails # 0042051 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,000)	294,641	294,641	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		9,417	5
6	Prepaid Insurance	780	5,725	6
7	Other Prepaid Expenses	3,448	4,710	7
8	Accounts Receivable (owners or related parties)	201,593	247,283	8
9	Other(specify): Due from 3rd parties	29,515	29,515	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 529,977	$ 591,291	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		221,765	11
12	Long-Term Investments		21,734	12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	31,126	31,126	15
16	Equipment, at Historical Cost	37,141	114,023	16
17	Accumulated Depreciation (book methods)	(21,633)	(178,987)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 46,634	$ 1,288,011	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 576,611	$ 1,879,302	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,531	$ 70,531	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,745	2,745	28
29	Short-Term Notes Payable		8,929	29
30	Accrued Salaries Payable	30,121	30,121	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,774	3,774	31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,984	32
33	Accrued Interest Payable		5,923	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	(accr ins, exps, idpa,sales tax, etc)	8,151	8,151	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 115,322	$ 143,158	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	221,765	1,087,154	39
40	Mortgage Payable		332,801	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owners Advances		19,095	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 221,765	$ 1,439,050	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 337,087	$ 1,582,208	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 239,524	$ 297,094	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 576,611	$ 1,879,302	48

***(See instructions.)**

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 114,527	1
2	Restatements (describe):		2
3	**external audit adjustments made after 2002 cost reports**	(14)	3
4	**was submitted. These hve no effect on prior years report:**		4
5	**Bad debt, medicare revenues (non-allowables)**		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 114,513	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	125,011	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 125,011	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 239,524	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,115,379	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,115,379	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous income w/g service fee**	59	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 59	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,115,452	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	133,201	31
32	Health Care	370,051	32
33	General Administration	230,083	33
	B. Capital Expense		
34	Ownership	222,736	34
	C. Ancillary Expense		
35	Special Cost Centers	7,976	35
36	Provider Participation Fee	66,637	36
	D. Other Expenses (specify):		
37	**Related party salary allocations**		37
38	**not to be included on this page, but**	(40,243)	38
39	**included on page 3 and 4.**		39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 990,441	40
41	**Income before Income Taxes (line 30 minus line 40)****	125,011	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 125,011	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Page 19A

Must be submitted if there is a balance on Line 28. You need only report the info that has a balance.

Call Pendant (private only, not offset on Schdl V)	0.00
Wellness Fee (private only, not offset on Schdl V)	0.00
TV Rental (private only, not offset on Schdl V)	0.00
Furniture Rental (private only, not offset on Schdl V)	0.00
Room Service (private only, not offset on Schdl V)	0.00
Housekeeping (private only, not offset on Schdl V)	0.00
Telephone (private only, not offset on Schdl V)	0.00
Meals (private only, not offset on Schdl V)	0.00
Ice Cream Shop (private only, not offset on Schdl V)	0.00
Vending Machine Income (is offset againts line 2, Schdl V.)	0.00
Late Fee Charge (private only, not offset on Schdl V)	0.00
Guest Suite (private only, not offset on Schdl V)	0.00
Community Fee (private only, not offset on Schdl V)	0.00
Miscellaneous Income gl 4977 (describe) (is offset againts Schdl V.)	58.50
Day Training Income (not offset, actual costs reported)	0.00
Recovery of Bad Debts (private only, is not offset on Schld V)	0.00
	0.00
Write Off of Old Amounts Due (related to prior yr, not offset on Schdl V)	0.00
	0.00
Gain on Sale of Assets (related to prior yr, not offset on Schdl V)	0.00
Total of line 28	58.50

Miscellaneous income is w/g service fees

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	651	693	$ 20,952	$ 30.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,722	1,722	47,088	27.34	3
4	Licensed Practical Nurses	2,620	2,879	58,900	20.46	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	373	453	4,756	10.50	14
15	Cook Helpers/Assistants	3,831	3,868	42,570	11.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	678	678	5,549	8.18	18
19	Laundry					19
20	Administrator	650	669	15,720	23.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,984	2,112	30,573	14.48	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,577	22,356	215,398	9.63	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	34,086	35,430	$ 441,506 *	$ 12.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	384	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	9	1,586	11-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	$ 5,970		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
various executives	execut mgmt	0	7,645
D. Moller	administrator	0	15,720
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 23,365

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 77,743
BDO Seidman	Accounting fees	3,397
Kenneth Fisch/Barry Greenburg	Legal fees	1,661
Neal Gerber & Eisenberg LLP	Legal fees	63
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 82,864

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,058
Unemployment Compensation Insurance	14,120
FICA Taxes	30,389
Employee Health Insurance	4,583
Employee Meals	3,515
Illinois Municipal Retirement Fund (IMRF)*	
Life and Dental Insurance/Pension	39
Miscellaneous Payroll costs	244
401K Match	1,172
Employee vaccinations	651
Related Party	5,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 71,370

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	138
Health Care Worker Background Check	28
(Indicate # of checks performed 4)	
Related Party Ams	55
Surety Bond fees	100
IHCA dues	604
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 924

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Insurance and Repairs	359
Gasoline	972
Related Party-AMS	1,216
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,547

**See instructions.

Facility Name & ID Number Alden Trails # 0042051 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Healthcare Assoc $865**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,066** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,637**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,515** Has any meal income been offset against related costs? **no** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? YES (this cl
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Bdo Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not yet Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Reporting Period Beginning 1/01/03
Reporting Period Ending 12/31/03

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description	
2		(3,515)	Employee Meal	
	22	3,515	Employee Meal	
22		(265)	Uniforms	265
	10		Uniforms	
	6		Uniforms	
	4		Uniforms	
	1	265	Uniforms	
	3		Uniforms	
	11		Uniforms	
	21		Uniforms	
		0	Net should be 0	